

**Utah Department of Health, Bureau of Epidemiology**

Investigator's name: _____		Date of interview: ____/____/____		Outbreak: <input type="checkbox"/> yes <input type="checkbox"/> no	
<b><u>PATIENT INFORMATION:</u></b>					
Last name: _____				Birth date: (m/d/y) ____/____/____ Age: _____	
First name: _____				SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street address: _____				<b><u>RACE</u></b>	
City: _____ Zip: _____				<input type="checkbox"/> Asian/Pacific Islander	
County: _____				<input type="checkbox"/> Black	
Home Phone #: (____) _____ Work Phone #: (____) _____				<input type="checkbox"/> White	
				<input type="checkbox"/> American Indian or Alaskan Native	
				<input type="checkbox"/> Unknown	
Occupation: _____				<b><u>ETHNICITY</u></b>	
Employer/School: _____				<input type="checkbox"/> Hispanic	
Did the patient attend or work at the following in the _____ hours/days/weeks* before onset of symptoms?					
Foodhandler <input type="checkbox"/> Yes <input type="checkbox"/> No					
Daycare <input type="checkbox"/> Yes <input type="checkbox"/> No Name of establishment: _____					
Nursing home <input type="checkbox"/> Yes <input type="checkbox"/> No					
Patient care <input type="checkbox"/> Yes <input type="checkbox"/> No Phone #: (____) _____					
<b><u>DISEASE AND RANGE FOR INCUBATION PERIOD:</u></b>				<b><u>LABORATORY DATA:</u></b>	
<input type="checkbox"/> Amebiasis (2-4 weeks)				Name of laboratory: _____	
<input type="checkbox"/> Giardia (5-25 days)					
<input type="checkbox"/> E. coli O157:H7 (3-8 days)				Lab phone #: (____) _____	
<input type="checkbox"/> Salmonella (6-72 hours) serotype: _____				Specimen: <input type="checkbox"/> Blood	
Shigella (12-96 hours):				<input type="checkbox"/> Stool	
<input type="checkbox"/> flexneri				<input type="checkbox"/> Urine	
<input type="checkbox"/> sonnei				<input type="checkbox"/> Other: _____	
<input type="checkbox"/> other (specify) _____				Date collected: ____/____/____	
Campylobacter (1-10 days):				Date of lab test: ____/____/____	
<input type="checkbox"/> jejuni					
<input type="checkbox"/> unknown					
<input type="checkbox"/> Other disease (specify): _____					
<b>CLINICAL DATA:</b> Physician: _____ Phone #: (____) _____					
Antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates treated: ____/____/____ to ____/____/____ Name of antibiotic: _____					
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?					
Date of admission: (m/d/y) ____/____/____ Date of discharge: (m/d/y) ____/____/____					
Died? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (m/d/y) ____/____/____					
Date of onset of symptoms: (m/d/y) ____/____/____					
Symptoms during illness:					
Abdominal pain/cramps		Y	N	U	
Bloating		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache
Chills		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
Bloody		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
Fever		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
degrees ____ days ____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain
Gas		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Nausea
					<input type="checkbox"/>
					Vomiting
					<input type="checkbox"/>
					Weight loss
					<input type="checkbox"/>
					pounds ____
					Other:

\*Fill in the number and circle the time period based on the range of the incubation for the disease. (See "Disease and range for incubation period")

**EXPOSURE/TRANSMISSION:**

Were there any household or non-household contacts recently ill with similar symptoms?

☐ Yes ☐ No

Name	Age	Sex	Relationship	DCC/School/Occupation	Symptoms	Date of Onset
1. _____	_____	_____	_____	_____	_____	____/____/____
2. _____	_____	_____	_____	_____	_____	____/____/____
3. _____	_____	_____	_____	_____	_____	____/____/____

In the past \_\_\_\_\_ hours/days/weeks\* prior to onset of symptoms, did the patient:

Travel outside the USA? ☐ Yes ☐ No

If yes, describe (where, dates of travel, type of food):

Travel inside the USA? ☐ Yes ☐ NoTravel outside of county? ☐ Yes ☐ NoHave any foreign visitors? ☐ Yes ☐ NoEat imported foods? ☐ Yes ☐ No**FOOD HISTORY:**

At what store(s) does the patient shop for groceries? \_\_\_\_\_

What is the water supply? Home: \_\_\_\_\_ Work: \_\_\_\_\_ School: \_\_\_\_\_

List restaurants, food establishments or group gatherings visited within \_\_\_\_\_ hours/days/weeks\* prior to the onset of illness.

Name	Address	Date exposed	Foods eaten
1. _____	_____	____/____/____	_____
2. _____	_____	____/____/____	_____
3. _____	_____	____/____/____	_____

If others accompanying the patient became ill with similar symptoms, please list under "Exposure/Transmission."

Did the patient eat the following within \_\_\_\_\_ hours/days/weeks\* prior to onset of symptoms? (Not for Amebiasis, Shigella, or Typhoid)

Food	Y	N	U	Date Eaten	Describe brand or place of purchase:
1. Poultry or packaged cold cuts (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
2. Raw or undercooked meats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
3. Unpasteurized (raw) milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
4. Other unpasteurized milk products (Cheese, cream, ice cream) (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
5. Raw or powdered eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
6. Raw or partially cooked seafood or fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
7. Cream filled pastries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
8. Powdered milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
9. Health food products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
10. Infant food or formula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
11. Other unusual food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	
12. Untreated Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	

**OTHER EXPOSURES:**Was there contact with pets or animals within \_\_\_\_\_ hours/days/weeks\* prior to onset? ☐ Yes ☐ No

If yes, please circle:

cats	farm animals	parakeets
dogs	chickens	pigeons
mice	ducks	guinea pigs
rats	rabbits	hamsters
reptiles		
other: _____		

Was/were any animal(s) sick about the time of onset? ☐ Yes ☐ No

If yes, describe \_\_\_\_\_

Within \_\_\_\_\_ hours/days/weeks\*

prior to the onset of illness, did the patient have or participate in:

Colonic irrigation ☐ Yes ☐ NoOther GI procedure ☐ Yes ☐ NoHiking ☐ Yes ☐ NoCamping ☐ Yes ☐ NoFishing ☐ Yes ☐ NoHunting ☐ Yes ☐ NoSwimming ☐ Yes ☐ NoRiver rafting ☐ Yes ☐ No**Additional comments:**